Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTH TEXAS RADIOLOGY IMAGING CENTERS
P.O. BOX 29490
SAN ANTONIO, TX 78229-09490

Respondent Name

FARMINGTON CASUALTY CO

Carrier's Austin Representative Box

Box Number 05

MFDR Tracking Number

M4-12-1794-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Patient stated services which were provided were covered under worker's compensation claim."

Amount in Dispute: $191.19

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider's Request for Medical Fee Dispute Resolution involves reimbursement for diagnostic services. The Provider submitted billing for an X-ray. The Carrier reviewed the bill and denied reimbursement as this is a HCN-enrolled claim but the Provider is not a HCN provider. After requesting reconsideration, the Provider filed this Request for Medical Fee Dispute Resolution. The Provider contends they are entitled to reimbursement because "Patient stated services which were provided were covered under workers' compensation claim." The Claimant's employer enrolled in the HCN prior to the Claimant's date of injury, and the Claimant's injury is covered by the HCN. The Provider is not a contracted provider with Travelers' HCN. Neither the Provider not the Claimant contacted the Carrier to obtain authorization to treat outside the HCN. Consequently, the non-HCN Provider is not entitled to reimbursement from the Carrier for treatment of a HCN claim."

Response Submitted by: Travelers (Farmington), 1501 S. Mopac Expwy, Ste A-320, Austin, TX 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 11 & August 10, 2011	73070 and 73100	$191.19	$ 0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. Texas Insurance Code Chapter 1305 set outs the procedures for Workers' Compensation Health Care Networks.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 25, 2011
   - 45 – Charge exceeds fee sch/max allowable or contracted/legislated fee arrangement. You are not an authorized Travelers HCN Provider. At this time your services are being denied by the claim adjuster.
   - W1 – Workers Compensation State Fee Schedule adjustment. Subject to multiple procedure discounts and is paid at 100 percent of the fee schedule amount per the Texas Physician Fee Schedule, Medicare guidelines.

Issues

1. Is the Requestor eligible for Medical Fee Dispute Resolution pursuant to 28 Texas Administrative Code §133.305 and §133.307?

Findings

1. This dispute was filed at the Texas Department of Insurance, Division of Workers' Compensation (Division), Medical Fee Dispute Resolution section on February 08, 2012 for resolution pursuant to 28 Texas Administrative Code §133.307.

   28 Texas Administrative Code §133.305 (a)(4) defines a Medical Fee Dispute as "A dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for the treatment of that employee's compensable injury." Non-network health care is defined in Section (a)(6) of the same rule as "Health care not delivered, or arranged by a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 and related rules…" 28 Texas Administrative Code §133.307 (a)(1) similarly states that "This section applies to a request for medical fee dispute resolution for non-network or certain authorized out-of-network health care…" Therefore, pursuant to 28 Texas Administrative Code §133.307, the Divisions Medical Fee Dispute Resolution section may not address fee disputes involving health care delivered, or arranged by a certified network as defined by Insurance Code Chapter 1305, but may resolve disputes involving certain authorized out-of-network health care.

   Out-of-network health care is defined at Insurance Code Chapter 1305, section 1305.006 titled Insurance Carrier Liability for Out-of-Network Health Care. Explanation of benefits indicates that the Provider is not an authorized Travelers HCN Provider. No documentation was found to support that the health care in dispute is authorized, out-of-network health care pursuant to Insurance Code Chapter 1305. Therefore, the dispute may not be resolved pursuant to 28 Texas Administrative Code §133.307, and Medical Fee Dispute Resolution is not the appropriate venue for resolution of the dispute filed by the requestor.

Conclusion

For the reasons stated above, the Division concludes that Medical Fee Dispute is not the appropriate venue for resolution of the issued raised by the requestor. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	4/20/12 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.